

# Massachusetts Commission for the Deaf and Hard of Hearing

## CART Provider Request Fax Form

(Items marked with a arrow (➔) REQUIRED for form to be complete)

**Incomplete forms cannot be processed**

**Please fax to (617) 740-1880**

➔ Today Date:	➔ Your Name:		
➔ Your Phone #:	<b>Ext.</b>	➔ Your Fax #:	
➔ Your Agency:			
➔ Date(s) of Assignment:			
➔ Beginning Time of Assignment:		➔ End Time of Assignment:	
➔ Location/Address of Assignment: (include bldg., floor, and room #) _____ _____			
➔ On-site Contact Person:		➔ Phone # On-site: <b>Ext.</b>	
➔ Description of Situation/Nature of Assignment (if follow up, please describe): _____			
➔ Names of Deaf or Hard of Hearing Person(s):			
Requested CART Reporters (unless otherwise specified by requestor, Referral Service will also check with other qualified Providers if requested Providers are unavailable):			
Total # of Participants		Other Agencies Involved:	
<div style="display: flex; justify-content: space-between;"> <div> <b>Equipment:</b> Please check # of users            1-2 users - laptop: _____            1-3 users - monitor: _____            More than 3 users - projector: _____         </div> <div> <b>Please check if equipment loan is needed:</b> _____            Combo projector: _____            LCD plate: _____            Screen: _____         </div> </div>			

### Billing Information

**(Request will NOT be processed without billing information)**

➔ Contact Person:	➔ Phone Number: <b>Ext.</b>		
➔ Agency Name:			
➔ Street Address:			
➔ City:	➔ State:	➔ Zip:	

**I have read MCDHH Interpreter/CART Referral Service Policies and Procedures, and, by signing my name below, a) certify that all information is correct and b) I agree to adhere to all terms and conditions.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Title

### OFFICE USE ONLY

Area:	Job #:
Received By:	Entered By: